

July 28, 2003

Montana Medicaid Notice

Hospitals, IHS, RHC, FQHC, Physician and Mid-Level Practitioners

Hysterectomy Requirements

When sterilization results from a procedure performed to address another medical problem, it is considered a medically necessary sterilization. These procedures include hysterectomies, oophorectomies, salpingectomies and ochiectomies. Beginning July 1, 2003, every claim submitted to Medicaid for a medically necessary sterilization must be accompanied by one of the following:

- A completed *Medicaid Hysterectomy Acknowledgement* form (MA- 39). The client must sign and date this form at least 30 days prior to the hysterectomy.
- For clients who have become retroactively eligible for Medicaid, the physician must certify in writing that the surgery was performed for medical reasons and must document one of the following:
 - The individual was informed prior to the hysterectomy that the operation would render the client permanently incapable of reproducing.
 - The reason for the hysterectomy was a life-threatening emergency.
 - The client was already sterile at the time of the hysterectomy and the reason for prior sterility.

The *Medicaid Hysterectomy Acknowledgement* form and instructions for completing it are attached.

Contact Information

Replacement pages for the *Physician Related Services* manual that cover hysterectomies (dated 06/01/03) are available on the Provider Information website:

<http://www.mtmedicaid.org>

For claims questions or additional information, contact Provider Relations:

Provider Relations in Helena and out-of-state: (406) 442-1837

In-state toll-free: 1-800-624-3958

MEDICAID HYSTERECTOMY ACKNOWLEDGMENT

A. RECIPIENT ACKNOWLEDGMENT STATEMENT	
I certify that prior to the surgery (hysterectomy), I received both orally and in writing information which explained that I would become permanently sterile and that I would be incapable of reproducing children after the surgery is completed.	
Signature of Recipient: _____ Date: _____	
PHYSICIAN ACKNOWLEDGMENT STATEMENT	
I certify that prior to performing the surgery, I advised _____ <div style="text-align: right;"><small>(Name of Recipient)</small></div> both orally and in writing that the surgical procedure known as a hysterectomy would render her permanently sterile and that she would be incapable of reproducing children after the surgical procedure is completed. I also certify that this procedure is being done primarily for medical reasons other than sterilization.	
Signature of Physician: _____ Date: _____	
SIGNATURE OF INTERPRETER (If Required)	
Signature of Interpreter: _____ Date: _____	

B. STATEMENT OF PRIOR STERILITY
I certify that _____ <div style="text-align: center;"><small>(Name of Recipient)</small></div> was already sterile and unable to bear children at the time the hysterectomy or other procedure capable of causing sterility was performed. The cause of this recipient's sterility was: _____ _____ _____
Signature of Physician: _____ Date: _____

C. STATEMENT OF LIFE THREATENING EMERGENCY
I certify that the hysterectomy or other sterility causing procedure performed on _____ <div style="text-align: right;"><small>(Name of Recipient)</small></div> was completed under a life threatening emergency situation in which prior acknowledgment was not possible. The nature of the emergency was _____ _____ _____
Signature of Physician: _____ Date: _____

This form may also be used as a substitute for the sterilization consent form for sterilization procedures where the patient is already sterile and for sterilization procedures (i.e., salpingo-oophorectomy, orchiectomy) done only for medical reasons. With these cases, replace "hysterectomy" with the appropriate procedure name.

Instructions for Completing the *Medicaid Hysterectomy Acknowledgment* Form (MA-39)

A. Recipient Acknowledgment Statement

This section is used to document that the client received information about the hysterectomy before it was performed. The client and the physician complete this portion of the form together with an interpreter if applicable. The client must sign and date this form at least 30 days prior to the hysterectomy. Do **not** use this section for cases of prior sterility or life-threatening emergency.

1. The client or her representative must sign and date the form at least 30 days prior to the procedure.
2. Enter the client's name.
3. The physician must sign and date the form.
4. If interpreter services are used, the interpreter must sign and date the form at least 30 days prior to the procedure.

B. Statement of Prior Sterility

Complete this section if the client was already sterile at the time of her hysterectomy or other sterilization causing procedure (e.g., salpingo-oophorectomy or orchiectomy).

1. Enter the client's name.
2. Explain the cause of the client's sterility (e.g., post menopausal, post hysterectomy, etc.).
3. The physician must sign and date this portion of the form.

C. Statement of Life Threatening Emergency

Complete this section in conjunction with Section A in cases where the *Medicaid Hysterectomy Acknowledgment* could not be completed prior to the surgery because of a life threatening emergency.

This section may be substituted for the *Informed Consent to Sterilization* for sterilization procedures (e.g., bilateral salpingo-oophorectomy or orchiectomy) done only for medical reasons. In these cases, replace the word "hysterectomy" with the appropriate procedure name.

1. Enter the client's name.
2. Explain the nature of the life-threatening emergency.
3. The physician must sign and date this portion of the form.